MINISTRY OF HEALTH

COMMUNICATION BETWEEN DOCTORS, NURSES AND PATIENTS

AN ASPECT OF HUMAN RELATIONS IN THE HOSPITAL SERVICE

Prepared by
A Joint Sub-Committee of the Standing Medical and Standing Nursing Advisory Committees for the Central Health Services Council and the Minister of Health

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REPORT OF A JOINT SUB-COMMITTEE ON COMMUNICATION BETWEEN DOCTORS, NURSES AND PATIENTS—AN ASPECT OF HUMAN RELATIONS IN THE HOSPITAL SERVICE

Introduction

1. We were appointed in December, 1961, with the following terms of reference:—

"(i) To consider what general principles and practical procedures may best provide hospital patients (and their relations) with the information they should have on their diagnosis, prognosis and treatment;

(ii) to make arrangements for any necessary inquiries to that end; and

(iii) to advise on the most appropriate means of drawing any recommendations to the notice of the professions."

Our appointment followed an inquiry from the Minister of Health to the Committees as to whether useful advice could be given by them on the subject of better communication between doctor and patient, a feature of much of the complaint that is received about the National Health Service. The Committees agreed that there was a primarily professional problem that ought to be reviewed.

In order to avoid misunderstanding, however, we wish at the outset to stress that, considering the hundreds of thousands of patients seen daily in hospitals, well grounded criticism is rare. But where failure of communication occurs, the repercussions are widespread and give rise to considerable and often disproportionately adverse comment, both private and public.

The scope of our report

2. Our terms of reference are, on the face of them, narrow and deserve some consideration.

A complete health service exists to provide as effectively as possible a medical (and often a medico-social) solution to the problems of its users but it is important to satisfy them that this has been done. Good relationships between the service and the user, depending on good communication, are essential and these, in a highly complex service, hinge on a multitude of inter-related factors. Obviously the physical circumstances in which patients are treated, e.g. old buildings, crowding, lack of privacy, etc. may predispose to, though they are rarely the cause of a patient's complaints or hostility. Communication is not made easier if facilities for it, notably secretarial services, cannot be provided. Doctors and nurses are not the only professional workers concerned directly with patients and their families; we think at once of ministers of religion, almoners and social workers. In a complex institution the problem of communication between all these interested parties is large and subtly entangled. Nevertheless, at the core is the relationship between doctors, who are the central figures in the patients' situation, and nurses, who are constantly in contact with the patient, and the patient himself. This relationship, on which our report focusses attention, is aptly expressed in terms of communication between all three about what is most important to the patient himself,

namely his diagnosis, prognosis and treatment. These relationships cannot he wholly isolated from their hackground, hut attention can properly he focussed on them ; and this is the ohject of our report.

3. Inter-relationships of this kind are a central prohlem of the health service as a whole. They are prohahly most difficult in the hospital, which is relatively remote and unfamiliar, and especially in the acute general hospital to which we mainly refer ; and it may, therefore, he thought impossihle to formulate recommendations which will cover the infinite variety of situations which must arise. Nevertheless, we think our views are, with suitahle modification, of general application.

We hope that they will he hrought to the notice of professional people in the Health Service hut we recognise that communication is a prohlem which affects and must interest a wider puhlic.

4. For convenience, we set out helow a summary of the main points that we make : —

(i) Encouragement should he given to further studies of patients' reactions to treatment and the prohlems these raise for doctors and nurses, hut the experience already availahle leads us to make recommendations which, if acted upon, could make a helpful contrihution to hetter communication. (Paragraphs 5-9).

(ii) The best features of good general practice, especially the continuing responsihility of the practitioner for his patient's welfare, set a useful pattern for hospital work. The general practitioners can greatly help the hospital hy telling the patient why he is going there and what to expect, and hy giving the hospital the fullest relevant information. The hospital should give advance notice of discharge and a full report thereafter. Close contacts hetween general practitioner and hospital can help good communication hy hoth. (Paragraphs 10-13).

(iii) At out-patient departments, patients should he treated on an individual hasis from the outset. The doctor should explain what is being done hy way of investigation and treatment, including the reasons for reference to another department ; there should he no surprises. No patient should leave the out-patient department without the advice and information he has the right to expect. The general practitioner must know what the patient has heen told. (Paragraphs 14-17).

(iv) Explanatory pamphlets telling the patient ahout the hospital can only ease the sudden transition to in-patient life ; good arrangements for reception are necessary. When there, the patient does not lack contacts hut may find it difficult to ohtain authoritative advice. Our view is that a " personal doctor " can supply the need, and that he should he the consultant or a doctor designated hy him. (Paragraphs 18-20).

(v) The personal doctor should identify himself as such to the patient. He should listen to his prohlems ; explain what is the nature and purpose of investigations and reassure him ahout his treatment and its aftermath. Responsihility for the final report to the general practitioner might fall to the personal doctor. (Paragraph 21).

(iv) In the absence of the medical staff, the ward sister accepts responsibility for ensuring that patients are told what they need to know. (Paragraphs 22-23).

(vii) Arrangements for relatives to see the doctor should be precise and made widely known. (Paragraph 24).

(viii) Timing of information should be carefully considered. Ward conferences can help to secure consistency of information. The existence of a single clear medical record moving with the patient is important. (Paragraph 25).

(ix) Doctors and nurses should be identified to patients by name. (Paragraph 26).

(x) Experienced doctors and nurses know the importance to good communication of a background of confidence and should emphasise it to their juniors. Difficult conditions do not justify poor methods. (Paragraphs 27-28).

(xi) The communication problem calls for a personal answer rather than a set of rules. Since experience during training has lasting effects the approach of hospitals with training responsibilities is important. (Paragraph 30).

(xii) Though this report concentrates on the responsibilities of doctors and nurses in daily contact with patients, the responsibility of management for encouraging high standards must not be overlooked. (Paragraph 31).

Patients, doctors and nurses

5. Little is known *objectively* about patients and their reactions to treatment. There has been much research in America—little elsewhere—and differences of attitude and cultural background may militate against deductions being made from foreign experience. Our attention has been drawn to two helpful studies of fairly considerable scope—one an extensive account of the comments of a sample of patients in a Scottish hospital after leaving hospital (1) and another an account of the ideas developed by study groups in a number of countries, including the United Kingdom (2). We have also taken note of a small study in a Manchester hospital of the reactions of in-patients to hospital life (3).

6. Our terms of reference empowered us to make or arrange for inquiries for our purposes. We have balanced the practicability and possible advantage of doing so against the time required and have concluded that we should not do so. An analysis of complaints reaching the hospitals and the Department would have been possible but would have been inadequate in scope and possibly misleading. The kind of studies in depth that will throw most light on patients' attitudes take much time to organise. We have learnt of a few such studies now in progress in University departments or supported by the Nuffield Trust and King Edward's Hospital Fund. We hope

(1) *The Patient's Attitude to Nursing Care*—Anne McGhee, (E. & S. Livingstone, 1961)

(2) *People in Hospital*—Elizabeth Barnes, (Macmillan, 1961)

(3) *The Patient's View of the Hospital*—S. C. Haywood, R. E. Jefford, R. B. K. MacGregor, K. Stevenson and G.D.E. Wooding Jones (*The Hospital*, October, 1961, pages 644—650).

that those who are undertaking such inquiries will receive help and encouragement.

We do not think it justifiable to await the results of these inquiries before reporting. There is a body of experience available, including our own, from which we believe helpful conclusions can be drawn and recommendations made that should be considered and discussed forthwith, since lay, medical and nursing press all reflect the increasing recognition of the need to improve communications.

7. *The Patient's Point of View.* Generalisation about patients is obviously not without its dangers. Age, sex, social and cultural and religious—even regional—backgrounds may all have their influence on how patients react to their illnesses and there is no certain way of associating any one of these factors with any one kind of reaction. As seen by doctors and nurses there is a wide variation in patients' responses to illness and hospital. Some patients may seem to them to regress readily to child-like dependence ; some are apathetic ; some strongly resent dependency, perhaps for the first time, on strangers and some relieve their feelings by an aggressive attitude for which there seems no warrant. Patients are in contact with the hospital staff for too short a time for any penetrating study of their individual characters to prove fruitful. It may perhaps be said of the generality that :—

(*a*) To most new patients the hospital is an unfamiliar institution, benign in intention but authoritative and mysterious.

(*b*) Most are anxious about their illness, about diagnostic procedures (some unpleasant in prospect), about prognosis and about treatment ; they may be frankly fearful of anaesthesia and surgery and of residual disability. To many the contrast between hospital realities and the possibly romantic picture of hospital life that books, films, radio and television have presented to them may be wholly bewildering.

(*c*) They are particularly anxious that the doctors should know all the facts that they think are relevant though their ability to express what they think and feel may be limited.

(*d*) Though some patients prefer—or appear to prefer—not to know much about their condition, most, understandably, want to know what is wrong with them, what is being and will be done. So that they can arrange their lives they will wish to know how long they will remain in hospital and what they must expect and do thereafter. Their problems outside the hospital—the job or the home and children—may worry them even more than their illness.

(*e*) They often need emotional support and some may attach themselves or refer to any suitable or unsuitable person to achieve this, if they do not receive it from those best fitted to give it.

(*f*) Patients vary greatly in their ability to understand. What seems to the doctor or nurse to be simple, straightforward information may not be understood or absorbed even by the intelligent layman. Patients will seize on the fact or the implication that seems of immediate importance and may be hard to persuade to apply their minds to other pertinent facts about their condition or treatment that doctors and nurses must try

to instil. They may well fasten on evidence of uncertainty or contradiction and seek confirmation from others of statements they distrust or wish to disbelieve. Those who have a wider knowledge resent its being underrated. The encouragement given to the public in various ways to take a greater interest in their health and in medical matters is often criticised because it may give rise to uncertainties. We welcome wider public knowledge, but welcome or not, it is a fact to he reckoned with, and not to be used as an excuse for poor relationships and unjustifiably restricted communication.

(*g*) It must he acknowledged, that many criticisms express a fear that patients who complain or do not readily conform are liable to reprisals from "authority" in one form or another. However unreal the fear, it clearly exists and must be counteracted and dispelled.

(*h*) The difficulties and anxieties of patients' relatives and their need for information and advice may be almost as great as those of the patient.

These generalisations will, we helieve, he readily accepted hut they are no more than generalisations. The prohlem remains of identifying and assessing what are the adverse factors in the individual patient, and these are seldom easily discernible (especially to the inexperienced), and of adjusting professional attitudes accordingly.

The Hospital Staff

8. To generalise about the doctors and nurses to whom the prohlem is set is hardly less dangerous. They are expected, as professional people, to give devoted, conscientious and effective service. It is not always so readily appreciated that they too are human and that the criticism to which they are sometimes suhjected must often seem to them to be uninformed and to savour of ingratitude. Nor are the inevitahle pressures of hospital work which can hamper effective mutual understanding always sufficiently appreciated.

Time is seldom on the side of the hospital staff. Work and organisation in hospital are of necessity fragmented ; many departments may be concerned with one patient and within each department there may be a hierarchy of responsibilities. The husiness of internal communication in such an organisation is itself difficult enough. Moreover, the illness which hrings the patient to the hospital is the urgent primary problem to which a medical solution must he sought and the complexities of the patient's whole problem cannot he allowed to overshadow this need. The doctor who treats and the nurse who cares for the patient may do so less effectively if they hecome too closely involved in his or her affairs ; but though emotional neutrality may be necessary it must not result in an appearance of aloofness or indifference. Indeed, that one "touch of nature which makes the whole world kin", which deals with patients as living, sentient beings, and not impersonally as "cases", is one of the most powerful aids to communication.

We have earlier emphasised that the hospital service can provide no stereotyped solution to the problems of communication. Patients have varying degrees of knowledge of medicine ; contemporary media for the dissemination of this knowledge inform but often distort ; patients' temperaments vary —from the apathetic and complacent to the aggressive and truculent. Indeed, patients present problems not only of illness but also of personality and these

are so diverse that this report can suggest only in broad outline how an answer to some of the problems of communication might be sought; it cannot provide a universal answer. It is obviously impossible to suggest what should actually be said to patients or relatives about matters of importance to them. Decisions about what to say and when—and to whom and by whom they should be said—can be made only by the doctor in charge of the patient, in consultation with the nurses whose contact with the patient will be more continuous. But it is essential that the need for a decision should always be in mind and that timely decisions should be made.

We do not overlook the important contribution that can be made through other links or by other professions. We think particularly of the useful links for example, between ward sisters, almoners and health visitors. The contribution that ministers of religion can make should be fully recognised. But responsibility can very readily be diffused when too many different hands are at work. The ultimate responsibility for the patient's treatment and aftercare lies with the doctors. If, as a general rule, hospital doctor and general practitioner, each in collaboration with those who work with them, communicate directly with each other, much confusion of purpose may be avoided.

9. In the following paragraphs we consider various stages of a patient's progress, where responsibilities lie, and, in general terms, some means of achieving desirable results. We appreciate that much of what is here set down is already in whole or in part established routine in many hospitals and clinics. We hope nevertheless that this report might lead to wider acceptance of our proposals for improving communication.

The Out-Patient

10. *The General Practitioner.* Almost all illness is seen first by the general practitioner. The patient usually comes to hospital because the general practitioner decides this is necessary—and the continuing care of almost all patients falls upon him after they have left hospital. He has direct personal responsibility for his patients, continuously and often over a long period. He may have attended them in earlier illnesses; he has the opportunity of knowing his patient and family, and the home and social background, and he may be in regular touch with them before illness occurs. He can be in a real sense a personal doctor whose helpfulness extends beyond episodes of illness. All the problems of variable human nature in illness that we outline above also come his way. His success or lack of success in coping with them is more readily apparent to him and lessons to be learnt from it may be more obvious because he lives with the results, as the hospital staff do not. He works against a less complex background (though with his ever increasing interest and responsibilities in social and preventive medicine he has become more and more the focus of the work of the local health authorities' team of home nurses, midwives, health visitors, social workers and home helps, and of the work of a variety of other organisations). While many of his problems in "communication" resemble those of the hospital staff—and we shall not stress them separately—he has, however, some advantage over the hospital doctor. But what is best in good general practice sets, to our mind, a pattern for what might be looked for in hospital. Here we consider mainly the link between the general practitioner and hospital staff.

11. The family doctor will have told his patient why he is being referred to hospital; he can allay the often unfounded fears of the patient about hospitals in general and, if he has personal contact with the staff, he can often anticipate and dispel prejudices and anxieties. Hence we hope that such contacts will increase.

12. The general practitioner can and usually does help the hospital staff in a number of ways. In addition to telling them the relevant clinical facts, he may be able to tell them what he knows about the patient and his circumstances. With this help, the hospital staff are better placed not only to receive the patient, to understand him and deal tactfully with his affairs, but also to make decisions from an early stage—as to the planning of treatment, discharge and after-care suitable to his needs. The family doctor can help particularly by making regular contact with the hospital, and by visiting his patient can make an important contribution to his welfare. It may sometimes be appropriate that it should be he, rather than hospital staff, who breaks unwelcome news to patients or relatives, as an expert friend rather than as a comparative stranger. He should be given every opportunity to introduce himself to medical and nursing staff and should be made welcome at any reasonable time.

13. When the patient leaves or no longer needs to attend hospital, responsibility passes to the patient's family doctor. The hospital owes him a duty, well recognised but not always well or promptly performed (sometimes, but rarely, because of pressure of work or lack of secretarial help) to tell him what is happening.

The family doctor ought to be told when one of his patients has been admitted from the waiting list or in emergency, not only because he should know what is happening to his patient but also that he may keep in touch with the patient and his family. Before the patient is sent home, transferred to another hospital or a convalescent or holiday home, the general practitioner should be given an *interim* report and told the date of the move. He should be told what diagnosis has been made in hospital, what treatment has been given and should be continued, what drugs, where appropriate, the patient will be given to cover any gap in medical care or, if that is desirable, will be prescribed, and whether and when the patient need return to hospital. He should be told also what has been said to the patient and relatives, and if, to save time, information has to be sent direct to the Medical Officer of Health or his staff, he should know of this too. A *full* report on the patient, including the results of special investigations should, of course, be sent with the minimum delay. It goes without saying that the family doctor should also be told if one of his patients dies in hospital.

The effectiveness of the general practitioner's own communication with patients who have been in hospital and with their relatives depends directly on these reports and the information they carry.

14. *The Out-Patient Department.* Most people have their main, possibly sole, contact with the hospital through the out-patient departments, where they are referred for consultation or for treatment beyond the scope of general practice. This trend is increasing and may well continue to do so, for the possibilities of out-patient rather than in-patient diagnosis and treatment are being more and more realised and provision made for them. The out-patient department is,

therefore, generally the first contact with the hospital and its medical and nursing staff and impressions gained here may set the tone of the patient's relationship with them, throughout his hospital experience. Certainly many complaints about the hospital service arise in the out-patient departments from what is alleged to he an indifferent or even unfriendly attitude on the part of those who deal with patients. Doctors and senior nursing staff working in these departments have the same responsihility for establishing good communication as in the wards. Since the general prohlems are the same, we draw attention here only to four aspects of out-patient work.

15. Conditions in out-patient departments are not always satisfactory—there is, no douht, much that management can do to improve arrangements for receiving patients, guiding them to where they go and dealing with inquiries. Where such difficulties exist there may well be delay in fixing the first appointment for a consultation and there are many complaints ahout this. Sometimes complaints would have heen obviated if the general practitioner had given a fuller picture of the patient's prohlem to the hospital—so that greater priority could be given—or had heen able to reassure the patient that some delay would not he detrimental to him. But the hospital can help hy carefully assessing needs on the information given and hy reminding the patient who has to wait that his family doctor is ready to see and help him if he is anxious ahout his condition in the meantime.

Complaints are sometimes directed, however, at the manner in which patients are dealt with in the department itself. The first aim should, of course, be to receive the patient on a personal and individual footing ; he should he addressed by name and not he given the impression of heing regarded as an impersonal case. " History-taking " is the normal and necessary first step, however adequate the reference from the general practitioner. Patients' reactions to it will vary. Some find it difficult to talk ahout intimate matters to an unfamiliar doctor and need encouragement and perhaps privacy before they unhurden themselves. With others the problem may be to stem the flood and guide it into useful channels. Patients who suppose that their family doctor has already told the hospital all ahout them may he somewhat surprised or even mildly alarmed at what they think are superfluous or irrelevant questions. It is not a waste of time to explain their purpose and this is always desirable where more than one doctor takes a history, either to check essential facts or as part of the discipline of medical education. Some emharrassment for the patient and some time for the doctor may he saved, if the patient is asked to fill up a simple form giving essential personal details, either when he first arrives or even hefore he attends. The necessity for much repetitive questioning may thus he avoided.

If the task has heen done completely—it cannot always be—the patient who later is admitted comes to a ward where the hasic information about him is already recorded.

16. The patient sent for consultation to the out-patient department, like the patient seen at a domiciliary consultation, remains the responsibility of the general practitioner, who, when diagnosis is estahlished, should receive advice on treatment from the consultant. He accepts the advice as a rule and, in practice also, accepts that in many cases it is desirable that the consultant should institute and perhaps complete treatment hefore returning the patient

to his care. One situation shades into another and there is a risk of the patient being left in unnecessary uncertainty. We think it entirely proper that to avoid this the patient should be told the essential facts and his questions should be answered before he leaves the hospital. Obviously, he should be told if he should attend again and why. He should be told if there is any need for him to be admitted, and if for any reason there must be delay this should be explained and reassurance about his condition in the meantime given. Or he can be told that further attendance at the hospital is unnecessary and that his own doctor will be advised about further treatment. The patient's own doctor must, of course, know what he has been told. It is clearly important if his confidence is to be maintained that the patient should not be given conflicting accounts from different sources.

17. Many patients are referred to other diagnostic departments either the same day or some later occasion, before firm decisions can be taken. In the process they may well be mentally if not physically "lost". We refer not to sign posts directing patients to different hospital departments, which might often be improved, but to ordinary straightforward information from the doctor about where he is sending the patient and why, how long the next phase will take and what is to be done after it.

The patient should be informed if the doctor is delayed or has arranged for certain investigations to be carried out before he sees the patient. Unpunctuality on the part of the patient or doctor—though often entirely explicable and excusable—may cause much irritation to both and disruption of the smooth working of the department.

Before any investigations are carried out, (for example, blood tests, barium enemas, etc.,) an explanation of what these involve should be given to the patient so that there are no surprises. If patients are referred to other clinics and will there see another doctor, e.g. a psychiatrist or gynaecologist, the reason for this reference should be emphasised to the patient in suitable and simple terms. The doctor to whom the patient was first referred should not only make sure of receiving the results of these investigations, and embody them where appropriate in the report which he sends to the family doctor, but he should also ensure that before a patient leaves the outpatient department all necessary information and instructions are clearly conveyed to him.

The patient in hospital

18. It is now much more common for patients to be given an introductory booklet before entering hospital on the lines recommended in the Central Health Services Council's report on "The Reception and Welfare of In-Patients," (1953). A recently published report by the King Edward's Hospital Fund for London ("Information Booklets for Patients") analyses what such pamphlets say and, incidentally, makes recommendations for useful improvements. They have an important part in easing the transition to life as an in-patient and we again commend them. Admission as an in-patient will still, however well prepared for, represent a considerable change from ordinary home life. The number of strange people around, new sights and sounds, the medical and nursing hierarchy, the necessary rules and the imposed orderliness of ward life are likely to be entirely new experiences for the patient. He

needs to be welcomed ; at least his arrival should he expected ; his records should he ready in the ward ; and it should not he necessary to cross question him again ahout elementary personal facts availahle in his records.

19. The first prohlem for the patient in the ward is, to whom to turn for authoritative advice and information. There are many possible sources. Most contacts are with junior nurses, whose relative importance and authority are unknown to him and who may he constantly changing from day to day or from shift to shift. Many contacts are with junior medical staff. Into the ward also come social workers, technicians, voluntary workers and others with special functions whose identity and purpose may be ohscure. At the end of the day—and nowadays often in the middle of it—come the visitors. There may indeed he no lack of outlets or possihle sources of information.

The authoritative figure whom he constantly sees is the ward sister, obviously in charge, expert, and closely in touch with the medical staff, hut in the nature of things less often availahle than other staff.

If the patient has not seen the consultant before admission, as must sometimes happen, he may not easily and quickly recognise him as the person who is clinically the most important figure in his case. The consultant will eventually he estahlished in the patient's mind as a man of authority for whom the work is organised, to whom all important matters are referred, and from whom final decisions come. But it will often seem to the patient that he is hardly ever present—at most for a relatively short time each day, when he is ohviously busy.

It cannot he surprising if patients are uncertain where to turn.

20. *The "personal doctor"*. We have noted that while living at home the patient has a personal doctor, the general practitioner, who can he expected to treat him as an individual and to interpret the arrangements for his care. The need for a similar service in hospital is not less great, for it is often at the time of serious illness that patients and relatives are under greatest stress. Yet it is not easy to reproduce in hospital the personal service which exists outside it. The consultant assumes responsibility for the patient's medical care, and in this respect is in the same position as the general practitioner. But it is difficult for him, unassisted, to provide a full personal service, among other reasons hecause he cannot always be in the hospital department or ward where it is needed.

We suggest that a serious attempt should be made to introduce the concept of a personal doctor in hospital. There can he little doubt that the best person to undertake this role is the consultant who has accepted clinical responsihility for the patient's care. But where circumstances prevent this the responsibility should pass (and should unambiguously he understood to pass) to the deputy who supervises the patient's medical care in the absence of the consultant. Under this arrangement a personal service would be seen not as a separate entity hut as an inseparable part of the wider concept of medical care. Unless the responsibility for personal care is clearly designated and accepted, there is a risk that failure of communication will occur.

Where the patient's prohlem presents particular difficulty, or cultural or language difficulties make poor communication likely, a heavier hurden will necessarily fall on the consultant.

21. Arrangements will no doubt vary from hospital to hospital. As soon as possible, however, the consultant should find occasion to identify himself to the patient. He should explain that an attempt will be made to provide a personal service, that he will be the personal doctor but that he may find it necessary to delegate this role to a colleague (who will also be identified). Clearly the most convenient occasion will have occurred already in the out-patient department, if the patient has been seen before admission. We refer to the importance of establishing a good relationship here in paragraph 15. He will be able to explain with authority the plan of investigation and later of the treatment that the patient is to have carried out, in a way suited to the patient's knowledge and understanding. Many patients, for example, are confronted on admission, not with treatments against which they have fortified themselves, but with an unexpected series of investigations, some (as they see it) unnecessary repetitions, some new and unpleasant in prospect. Most patients need reassurance about surgery and anaesthesia, from fear of the operation and anaesthetic or from anxiety about the aftermath.

The patient is usually anxious that the doctors should know all about him and it is sometimes overlooked that communication is an affair of two people, not simply of one " telling " the other. He is also often anxious about his progress, and his attitude may vary strikingly at different stages of his stay.

It is a truism, but not yet a universally applied truth, that rehabilitation begins when the patient is first seen. A personal doctor could help to make this a reality ; divided responsibility works against it. Certainly he can relieve some common anxieties. Patients want to know when they will be fit to leave hospital. When an intensive course of treatment ends (possibly abruptly) on which the patient's attention has been fixed he may need to be reassured that it is no longer necessary. He wants to know whether he will make a full recovery, and if so, when, approximately, he may be fit to return to work ; if recovery is to be incomplete, whether he will be able to return to his former job ; if not, what work, if any, will he be able to undertake ; and what of diet and exercise? A hundred and one personal questions may be posed, and need a sympathetic and informed reply. The Edinburgh study we have mentioned notes significantly that almost all the favourable comments by patients on good communication with doctors came from people with heart conditions or diabetes where it is medically necessary that such information should be given. Some patients may need much practical information about after care, benefits and other social services. If there is no almoner, the " personal doctor " should know who in the hospital can give this information or obtain it. Often enough, as in the out-patient department, the in-patient is the subject of consultation with other consultants. The " personal doctor " should explain the reasons for this to him and tell him, if possible, the outcome. It is at least disconcerting to be discussed by a stranger, who is by accident later discovered to be a surgeon or a psychiatrist.

When a patient is transferred to another department, he should know why this has been necessary. It may well be that such a transfer will mean, at any rate for a time, a change in the patient's personal doctor.

It will then often be convenient for the last personal doctor to have responsibility, before the patient's discharge from hospital, of tying up the loose ends. He will no doubt be the doctor responsible for reporting to the patient's family

doctor, after telling him that the patient is returning home. If so, the final report should convey sufficient information to enable the family doctor to continue care and should report what the patient and relatives have been told. The patient and his relatives should also know when the family doctor is likely to receive the report and, where necessary, the patient should be given an adequate supply of medicaments to bridge the interval between leaving the hospital and the receipt of the report.

22. *The Ward Sister.* The doctor cannot live on the ward. He relies on the nursing staff to tell him what they have observed and heard and to carry out the clinical tasks he gives them. This is the well understood and accepted ward practice. It does not always but should naturally extend to the processes and problems of communication that we are considering. The key figure is, of course, the ward sister. The patient looks upon her not only as the nurse in charge but as having a general authority, for she is seen to be closely associated with the consultant on his rounds and with junior medical staff in their daily work; she controls the nursing staff, of whom the patients see most. There should be close consultation between her and the personal doctor so that when the medical staff are not available she is well placed to ensure that the patient is told what he can and should be told. This is an important role in addition to the many others she must assume and ways must be sought to enable her to assume it.

23. As we have noted above, many others besides doctors and nurses enter wards for various purposes. All who come in contact with the patient—whether ward staff or staff from other departments—have a personal responsibility to encourage and comfort and to give their specific help. Nurses of all grades must as part of their work seek contact with the patient and make themselves familiar with the patient's condition. If the primary responsibility for communication rests with the personal doctor it is also necessary that one person on the ward staff must accept responsibility for what is said when he is not there. This responsibility can be carried at no lower level than that of the ward sister herself, her deputy acting for her in her absence. It is her duty to ascertain from the doctor what in general or in particular can be said, and by whom, about treatment and future prospects. She must instruct ward staff in the part that they are to play. Those to whom she does not entrust the task should not assume it without reference to her.

24. *The needs of relatives.* We have said earlier that relatives harbour anxieties and fears which may be hardly less distressing if different in nature, from those of the patient. Their need for accurate information may be no less pressing. Their anxieties may well be transmitted to the patient and the value of the good work done for him diminished. In the case of children, their co-operation is, of course, vital. It would be a counsel of perfection to suggest that the personal doctor should be as available to visitors as is the family doctor to relatives, especially as visiting is increasingly spread throughout the day. Nor is it possible for the ward sister always to be at hand. It should be possible, however, to arrange that someone is designated to be available to relatives who is accurately briefed on the patient's condition and prospects. Many consultants will doubtless themselves undertake this. If or when the consultant cannot do so, he should ensure that his deputy is ready to receive relatives once or twice a week at times likely to be convenient to

them, special appointments being made for those who cannot fit in with the fixed times. These arrangements should be made known to patients and relatives, possibly in the hospital's pamphlet. Complaints have often arisen because this kind of reassurance and information has been lacking.

25. *Other suggestions for securing better communication.* Time, timing and consistency of information are evidently of first importance. The patient has little to do but think and perhaps more time than on any other occasion to do so. The process of communication is, of course, continuous but information about particular matters ought to be timed to avoid both shock and an undue period of reflection (e.g. postponing an operation or investigation after a time had been fixed) and such privacy as is possible should be sought for discussion of personal affairs. Consistency presents greater problems, to which the best local solution must be sought, but we commend the present practice in many hospitals of arranging regular ward conferences of medical and nursing staff or briefing meetings before the consultant leaves the ward, so that all are aware of the patient's progress. It should not be ignored that the junior nurse or student, who sees the patient, may have an important contribution to make. So far as a piece of paper can help, a single master medical record comprising significant, clear information might be most helpful, moving wherever the patient moves and available as a full record to anyone concerned with the patient's care who needs to see it. This might be additional to necessary records kept in departments but would be available whenever the patient was seen. It should normally be kept in the office and not near the bed.

26. *Identification.* Many hospital pamphlets attempt to guide the patient through the hierarchial maze of medical, nursing and para-medical staff, for instance by describing differences in uniform. They cannot, however, tell the patient about the person with whom he has to deal. Yet personal identification facilitates communication. There is no reason, for example, why the doctor should be anonymous. It should, of course, be impossible to record that sensible patients can go through the whole process without knowing the name of the consultant responsible for them, yet it happens. It seems desirable that he and other doctors should be identified at least by desk plate or name badge, even if they do not introduce themselves directly. Patients fairly quickly observe, even without help, that there are subtle variations in the uniform of nursing staff, but often they have no idea of the status of the wearer—except that some may seem more awesome than others. Impartially, they are all thought of as just "Nurse". A name badge seems at least desirable.

We refer again to the desirability of identifying visiting personnel from other departments who are not usually in the ward, particularly medical students or research workers who are increasingly to be found in hospitals where their presence may not be expected. They cannot be readily identified and should introduce themselves and explain their purpose. Simply knowing a doctor's or nurse's name does not establish communication; it may, however, be an important step in converting an impersonal into a more human relationship. We think it is to be encouraged.

27. Experienced doctors and nurses have long recognised that if what is

said to the patient is to be fully significant it must he said against a background which generates confidence, hut this is achieved not only hy what is said but also by how it is said. For example, patients clearly should not see or hear, by gesture or word, what may react adversely on them. Conflicting statements may well shake the confidence of both patients and relatives. It is important that, both by precept and example, senior staff should emphasise to their juniors the importance of this aspect of communication.

28. Clear and effective communication depends partly on a realisation that what is familiar to hospital staff—the sights and sounds of ward life, sometimes distressing, and the lack of privacy which offends the modesty of many patients—is unfamiliar to the patient who may not understand or may find what he sees emotionally too exacting and a source of anxiety. A little thought may save him much pain.

Haste in handling a patient will of course, be avoided wherever possihle. The effect on ward patients generally of an unnecessary air of bustle and haste is less often realised. The peaks of effort that give rise to it can he avoided, it has heen shown, by reorganising the day's work (1) ; from this an improved hackground should result.

Arrangements for admitting and discharging (or transferring) patients are an example of this kind of management. It is clearly right to keep up the tempo of hospital work and not to leave expensive facilities unused. It may not, however, need much foresight or planning with the help of the administration, to secure that patients are not sent for to be admitted to hospital at unreasonahly short notice or that the arrival of an amhulance is not the first indication of a return home.

We accept that physical conditions and lack of time make difficult tasks more difficult ; we do not accept that they make them impossible.

Conclusion

29. In this report we have been acutely conscious that we are reaching towards a concrete expression of relationships between on the one hand the medical and nursing staff of the hospital and on the other their patients, and that this defies clear definition. Yet all doctors and nurses are, even if unconsciously, concerned in this most important prohlem of communication. No one will dispute that " communication " could he improved and that it is hest where there is the will to ensure that it shall he improved, but frequently it is neglected. This is not to lay a general accusation against our colleagues. It is simply to recognise that in the every day pressing activities of a hospital it can often he overlooked unless its importance is borne in mind. Most of our recommendations will not he novel to many who work in hospitals.

30. Everything depends, eventually, on the individual practitioner or nurse and on his or her willingness to review, with increasing experience, the " personal answer " to the communication problem to which we have earlier referred. It is self-evident that the thinking and practice of doctors and nurses is greatly influenced hy their experience during training and many of

(1) Report on the Pattern of the In-Patient's Day, (H.M.S.O.) 1961.

them aspire for the rest of their lives to reproduce the pattern of care which they saw as students. For this reason we attach particular importance to the approach to communications adopted in hospitals responsible for training doctors and nurses.

31. Finally, our terms of reference, as we have explained, deliberately leave aside questions broadly the concern of management and concentrate attention on the professions who are close to the patient, and in particular on the responsibilities of the consultant and the ward sister. We do not, however, overlook that management itself, in the persons of the governing body, of the lay officers or of the matrons, has a powerful influence on the atmosphere in which these responsibilities are exercised.

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